MDR Tracking Number: M5-04-2895-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 01-12-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The prescriptions for Carisoprodol, Promethazine, Pentazocine, Neurontin and Hydrocodone/APAP were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 07-30-03 through 12-09-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 29th day of July 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

July 16, 2004 **Amended letter 07/27/04**

MDR Tracking #: M5-04-2895-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the ___ in ___. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work-related injury on ___ when he was lifting heavy boxes and twisted his back. The patient complained of back pain radiating down his right thigh on the inner aspect down to the big toe. Following treatment, the patient underwent a myelogram with post-myelogram CT that indicated extruded fragment at L3-4, and a herniated disc at L4-5. The patient failed to improve with conservative therapy and underwent a left L3-4 and left 4-5 lumbar laminectomy/discectomy. A portion of the patient's therapy included prescriptions for Carisoprodol, Promethazine, Pentazocine, Hydrocodone/APAP and Neurontin.

Requested Service(s)

Prescriptions for Carisoprodol, Promethazine, Pentazocine, Hydrocodone/APAP, and Neurontin billed from 07/30/03 through 12/09/03

Decision

It is determined that the prescriptions for Carisoprodol, Promethazine, Pentazocine, Hydrocodone/APAP, and Neurontin billed from 07/30/03 through 12/09/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Carisoprodol, Promethazine, Pentazocine, Hydrocodone/APAP, and Neurontin are reasonable, commonly used, appropriate and medically necessary for treatment of the symptoms manifested in this patient. The symptoms are common after such injuries and can persist indefinitely.

Sincerely,